[Meeting topics: presentation by Watson Wyatt.]

MINUTES

HEALTH PLAN TASK FORCE

Thursday, January 21, 1999

10:00 a.m.

229 Nolte Center

Present: Richard McGehee (chair), Linda Aaker, Avner Ben-Ner, Richard Butler, Robert Fahnhorst, Bart Finzel, David Hamilton, Priscilla Pope, Harlan Smith, Robert Sonkowsky, Larry Thompson, Gavin Watt

Absent: Amos Deinard, Keith Dunder, Roger Feldman

Regrets: Richard Purple

Guests: Carol Carrier, Watson Wyatt Representatives

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1. Chair's Report

Professor McGehee reported that he had attended the State Labor Management Committee (SLMC) meeting on January 20, and felt more optimistic at its conclusion than he did at the December meeting. The SLMC was pleased with Governor Ventura's reappointment of Commissioner Sullivan and felt he will bring stability to the department. SLMC cited two reasons for the delay in implementing the new plan: 1) the process of securing bids for administration of the plan is not complete and 2) not all the care systems they would like to hear from have responded to the Requests for Qualifications. At this time, the SLMC expects to have some modification of the current system for the year 2000 and to switch to the care system approach in 2001.

There are five places, however, where the process could be derailed or delayed: 1) if there are not enough funds allocated in Governor Ventura's budget for the state to be self-insured, 2) if there are problems with the care systems administrators' bids, 3) if there is not enough care

system interest, 4) if the legislative appropriation expected in mid-May is not sufficient, and 5) at the bargaining table in June-July.

There is a lot of momentum for the new plan, said Professor McGehee. The Department of Employee Relations is committed to moving forward and the union representatives on the SLMC believe this is the right solution.

2. Watson Wyatt Report

Professor McGehee welcomed the Watson Wyatt (WW) representatives to the meeting and distributed the firm's report. Watson Wyatt was asked to access the viability of a 'U of M only' health care purchasing strategy (i.e. separate from the state), to compare health plan product features across the organizations, and to estimate the health care costs of U of M enrollees relative to the state. It is the consultant's opinion that the University does have options.

Looking at current trends, WW reported that there is health care consolidation at every level, the primary care provider gatekeeper approach is significantly losing momentum as research is showing that gatekeeping is actually less cost-effective than allowing patients to go directly to specialists, and there is a lot of movement in the market in trying to deal with the 'demand' side of the equation. That is, how the demand for health care can be changed. An example would be improving preventative opportunities. Changes are also occurring in how health care plans are administered and, finally, there are continuing changes in Medicare legislation.

Watson Wyatt looked at standard off the shelf products available to entities similar in size to the U of M and only fully-insured products, except the Buyer's Health Care Action Group (BHCAG) which is self-insured or self-funded. They included HealthPartners (HP), Medica, Blue Cross/Blue Shield (BCBS), and BHCAG. WW noted the importance of understanding whether a product is fully-insured or self-insured because with fully-insured products you may lose some flexibility with carriers. Typically, employers the size of the U of M are self-insured.

When Health Partners (HP) was approached, they did not offer HP classic (currently the most popular product for U of M employees) as a plan design option. It is WW's understanding that HP is maintaining that product but is now only offering it to companies with less than 50 employees. Similarly, Medica is not offering Medica Primary as an option to new employers. BCBS does not have a care system model but does offer better outstate options. If the University chooses to separate from the state, WW recommends it conduct a displacement analysis as one of its evaluation tools.

WW also noted that the study included the Twin Cities and Duluth markets, but not Crookston or Morris.

In response to a question about care systems, WW explained that with a care system a group of clinics and hospitals come together to form a system and employers contract directly with the system. In this model a physician and clinic are only associated with one care system. Employees select a system rather than a plan. Many physicians prefer this approach because they have a greater voice in the health care decisions. In a care system model, like BHCAG, each employee

and each of his/her dependents can choose his/her own care system and the premium will depend on which system the employee/dependent selects. Moreover, the providers set their own prices.

WW outlined the similarities and differences in the health plan products studied. Fully-insured managed care organizations offer very comparable products. Their plan designs and delivery systems are similar and all have out-of-network options. Some, like BCBS, will work with employers with special circumstances (e.g. sabbaticals). All offer coverage for out-of-area emergencies and the ability to choose one's own primary care provider and clinic. Moreover, they generally have comparably high HEDIS results (i.e. measurable data, such as average length of stay, etc). Employers who self-insure, however, have greater flexibility in the customization of a plan.

All the plans offer a care system model except BCBS. Medicare risk products are only offered by HealthPartners and Medica. BHCAG provides few plan design options at this time, but is interested in expanding its membership and most likely would be willing to customize a plan. All plans allow direct access, that is, without a referral, for OB/GYN, mental health, chemical dependency and routine eye exams except BCBS, which only allows OB/GYN and routine eye exams. BSBC is the only plan to offer U of M facilities as the primary care provider. Employees covered by HealthPartners and Medica also have access, but it is more expensive. All plans include the Duluth Clinic except HP, and HP has significantly less participating providers than the other plans in both the Twin Cities and Duluth. Medica is the only plan that does not require its members to select a primary care provider. From a quality standpoint, Medica and HP received full accreditation in 1996 by the Committee for Quality Assurance. WW clarified that the accreditation is overall, not in specific areas, like mental health. BCBS has the lowest percentage of board certified PCPs. Again, WW clarified that many health plans do not seek accreditation for a variety of reasons. They might include fear of failure to pass or the costs involved in applying. More and more plans, however, are seeking accreditation as employers consider it to be a minimum criteria.

The committee asked whether data is available at the product level. Watson Wyatt did not know off hand but will check on that. The Task Force also wondered whether there was any data to indicate that being certified improves mortality and morbidity. WW replied that there is mixed opinion regarding the accreditation process, but it appears the health industry is moving more toward outcome measures.

Turning to costs, WW reported that ChoicePlus under the BHCAG plan has the lowest per member per month (PMPM) rates for point of service/care system plans. BHCAG's intent is to control costs yet provide quality. Medica's PMPM rates appear high. Based on current rates, the PMPM premium that is being paid on a composite of all University plans is approximately $168, which is, in the consultant's opinion, very high. The national average for a typical HMO or point of service plan is $130-135.

Because the University is in the State Health Plan, it does not have 'experience' data that WW can use. Thus, WW had to make a set of assumptions about experience data to come up with a manual rate. To do this, WW took the demographics and ran them through a manual rating tool that simulates claims, using PreView simulation software. The results showed that in aggregate

the plans are about 20 percent below what the University is currently paying, equating to a PMPM rate of approximately $132, which is what one would expect as a norm on HMOs or point of service plans.

WW also looked at the information as compared to some benchmark data using two surveys--a Foster Higgins Survey based on 1997 figures and a Hay Huggins Survey based on 1998 figures. In general, the comparisons support the manual rates. Again, the one unknown is the degree to which U of M Employees use their health service. The state has argued that the state as a group has higher use than the state as a whole.

In conclusion, Professor McGehee said it appears from the data that the University is spending more than it needs to on its health plans. However, there are a number of unknowns and because 'experience' data is not available for U of M employees, some of the information provided by WW is based on a set of assumptions. An interesting piece of information that needs to be considered is WW's finding that U of M employees have on average fewer dependents than the average state-wide. That may be one of the factors driving the numbers.

Professor McGehee asked committee members to review the information provided during the next two weeks and invited Watson Wyatt to meet again with the Task Force on February 4. At that time the committee will look more specifically at the plans and discuss the issue of self-insured v. fully-insured.

The meeting was adjourned at 12 noon.

-- Martha Kvanbeck